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No. 97-53

IN THE

Supreme Court of the United States

OCTOBER TERM, 1997

JANE M. ROBERTS,
Guardian for Wanda Y. Johnson,
Petitioner,

v.

GALEN OF VIRGINIA, INC., Formerly d/b/a
Humana Hospital - University of Louisville,
Respondent.

On Writ of Certiorari
to the United States Court of Appeals
for the Sixth Circuit

BRIEF FOR THE AMERICAN HOSPITAL ASSOCIATION, AMERICAN MEDICAL ASSOCIATION, AMERICAN COLLEGE OF SURGEONS, AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS, CONGRESS OF NEUROLOGICAL SURGEONS, AND AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, AS *AMICI CURIAE* SUPPORTING RESPONDENT

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QUESTIONS PRESENTED

Amici believe that, in addition to the question presented by petitioner, this case also presents the following questions: Did respondent hospital violate the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd, by discharging an individual when (a) the discharge occurred after the individual had been admitted to a non-emergency department of the hospital for two months of treatment and (b) the individual's treating physicians did not believe that she had an emergency medical condition?

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INTEREST OF *AMICI* [1]

The American Hospital Association (AHA) is the largest national membership organization of hospitals in this country. Its membership includes approximately 5000 hospitals, health systems, networks, and other providers of care. The American Medical Association (AMA) is the largest national membership organization of physicians in this country. Its members include approximately 300,000 physicians, including many who provide emergency medical services in hospital emergency rooms. The American College of Surgeons (ACS) is the largest national membership organization comprised exclusively of surgeons in this country. Its members include approximately 56,000 surgeons, including many who provide emergency medical services in hospital emergency rooms. The American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS) represent over 4,500 practicing neurosurgeons in the United States. Their members are called upon to provide emergency medical services for a wide variety of conditions. The American College of Emergency Physicians (ACEP) is a professional and educational society of more than 19,600 emergency physicians who practice in emergency medicine departments across the country.

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[1] This brief is submitted with the consent of counsel for all parties. No person or entity, other than the *amici*, made any monetary contribution to the preparation of this brief. Counsel of record is counsel to the Chicago office of the law firm of Sidley & Austin. Lawyers in that firm assisted in the preparation of this brief. After counsel of record was retained by the *amici*, Mr. Carter G. Phillips, a partner in the Washington D.C. office of Sidley & Austin, was retained by respondent to serve as its counsel in this Court. However, neither Mr. Phillips nor anyone assisting him in the preparation of respondent's brief authored, in whole or in part, this brief.

The Emergency Medical Treatment and Active Labor Act ("EMTALA"), 42 U.S.C. § 1395dd, requires that every covered hospital emergency department provide an appropriate medical screening examination to any individual who seeks assistance at the emergency room. 42 U.S.C. § 1395dd(a). It further requires that hospitals take appropriate steps to assure that any transfer of an individual from an emergency room will not further impair the individual's condition. 42 U.S.C. § 1395dd(b). In enacting these limited but important federal duties, Congress sought to eliminate the practice of "dumping" uninsured patients who come to emergency rooms seeking assistance. The AHA, AMA, ACS, AANS, CNS, and ACEP fully support this statutory objective.

While supporting the purpose of EMTALA, *amici* also share the concern, voiced by virtually every court of appeals, *see infra* p. 9 n.5, that the Act not become a substitute for state medical malpractice liability. EMTALA contains language, such as the requirement that individuals be "stabilized" before they are transferred, that, if taken out of context and given an expansive interpretation, could create a federal cause of action that would duplicate the liability that already exists under state law. Construing EMTALA in this fashion could lead to a federalization of standards of medical care, would create widespread opportunities for forum shopping, and would undermine state efforts to reform their tort systems. *Amici* urge that this Court construe EMTALA in keeping with the intent of Congress to establish limited federal duties to screen and stabilize individuals who come to hospital emergency rooms seeking assistance -- and not to create a general federal cause of action for malpractice. Accordingly, *amici* support affirmance of the decision below.

STATEMENT

Wanda Johnson, petitioner's ward, was severely injured when she was struck by a truck while walking home from work. Ms. Johnson was not denied an appropriate medical screening examination at respondent's emergency room. Nor was she transferred from the emergency room to another hospital without first being stabilized. To the contrary, she was admitted to the University of Louisville Hospital for extensive and prolonged treatment. Petn. A27.[2]

Johnson was discharged from the hospital only after her physicians concluded that her condition had been stabilized and only after the hospital staff had identified a skilled nursing facility which would provide her appropriate rehabilitative care. J.A. 31-33, 116. The decision to discharge Johnson was regarded as medically appropriate by all of her treating physicians. J.A. 131, 133, 135. They testified, without contradiction, that financial considerations did not play a role in their discharge decision. J.A. 131, 133, 135.

Both of the lower courts recognized that imposition of EMTALA liability is not warranted on these facts. The Sixth Circuit observed that "EMTALA is not a substitute for state law malpractice actions, and was not intended to guarantee proper diagnosis or to provide a federal remedy for misdiagnosis or medical negligence." Petn. A10 (citation omitted). In order to keep EMTALA within its proper bounds, the court reaffirmed its decision in *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266 (6th Cir.

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[2] The Appendix to the Petition for Certiorari is cited as "Petn. A___." The Joint Appendix is cited as "J.A. ___."

1990), which it characterized as requiring EMTALA claimants to show some type of "improper motivation" on the part of the hospital before they may recover damages. *Id.* After reviewing the record, the court found there was no evidence that "Humana acted with an improper motive when it discharged Johnson." *Id.* A14.

SUMMARY OF ARGUMENT

EMTALA is a narrow statute designed to remedy a very specific problem, *i.e.*, the practice of a small number of hospitals in the 1980s of "dumping" individuals who presented at the emergency room with an emergency condition but no ability to pay. Although Congress created a private right of action for individuals directly injured by a hospital's violation of the federal duties created by EMTALA, there is no indication in the language of the statute or its history that Congress intended to create a general federal cause of action for malpractice in the emergency room setting. Every court of appeals that has considered the Act has recognized the importance of assuring that EMTALA's narrow federal duties do not mushroom into a substitute for state tort liability.

The Sixth Circuit's decision in *Cleland*, *supra*, interpreted EMTALA as requiring proof of a non-medical motive, other than mere negligence, as a condition of recovering damages in a private action. This implied limitation on EMTALA liability confines the statute to the perceived evil that gave rise to its enactment: It imposes liability on hospitals and physicians who dump individuals from emergency rooms because of their inability to pay or other non-medical reasons -- while avoiding invocation of EMTALA as a substitute for state malpractice law.

While *amici* support a narrowing construction of EMTALA, there is no need in this case to invoke the Sixth Circuit's implied mental state requirement in order to reach the right result and effectuate the intent of Congress. In addition to the improper motive test relied upon by the Sixth Circuit, two alternative grounds fully support the judgment below. These alternative grounds are solidly supported by the language and structure of EMTALA, and they have been endorsed by the courts of appeals. This Court should address these two alternative grounds and affirm the judgment of the Sixth Circuit.

First, the language and structure of the Act reveal that EMTALA's duties apply only where an individual comes to a hospital emergency room with an emergency medical condition, and the hospital either refuses to provide an appropriate medical screening examination or transfers the individual without first stabilizing the emergency condition. EMTALA provides no basis for extending these duties to individuals who come to an emergency room and then are *admitted* to the hospital for treatment. Once an individual is admitted for treatment, a hospital-patient relationship is established, and the quality of subsequent care is governed by well-established state law tort duties. In this case, Wanda Johnson was admitted to the respondent hospital, and received treatment for two full months. At that point, any controversy over whether she was properly discharged is governed by state law, not by the limited federal duties of EMTALA. If the hospital was negligent in discharging Johnson, she has a remedy under state tort law.

Second, the plain language of EMTALA indicates that a hospital's duties regarding stabilization before transfer apply only when an individual comes to the hospital "and the

hospital *determines* that the individual has an emergency medical condition." 42 U.S.C. § 1395dd(b) (emphasis added). As the lower courts have unanimously held, a hospital "determines" that an emergency medical conditions exists only if it has actual knowledge of such a condition. The evidence in this case is uncontradicted that Johnson's treating physicians did not believe that she had an emergency medical condition when they discharged her. Therefore, judgment should have been entered for the respondent hospital on the ground that the condition precedent to EMTALA liability for failing to "stabilize" an individual before transfer -- a determination that Johnson had an emergency medical condition -- had not been satisfied.

ARGUMENT

I. EMTALA CREATES A NARROW SET OF INTEGRATED DUTIES DESIGNED TO CLOSE A GAP IN STATE LAW THAT PERMITTED SOME HOSPITAL EMERGENCY ROOMS TO "DUMP" UNINSURED PATIENTS

A. EMTALA's Narrow Gap-Filling Purpose

Congress enacted EMTALA in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, 100 Stat. 82 (1986). The Act was passed in response to widespread publicity about episodes in which certain hospitals had apparently "dumped" individuals who came to their emergency rooms seeking treatment. In other words, individuals were reportedly turned away from the emergency room without being examined, or were shunted from private hospital emergency rooms to public hospitals without any examination or treatment, because they

were poor and lacked health insurance. *See* H.R. Rep. No. 241, 99th Cong., 1st Sess., Part I, at 27 (1985), reprinted in 1986 U.S. Code Cong. & Admin. News 579, 605; 131 Cong. Rec. S13,903-05 (1985) (remarks of Sens. Durenberger, Kennedy, Dole, Heinz and Proxmire).

Hospitals which engaged in emergency-room "dumping" were able to do so because, under the common law rule, physicians and hospitals have no affirmative legal duty to provide medical care to individuals with whom they have no prior relationship.[3] In general, the common law limits the liability of physicians and hospitals to those individuals with whom they have agreed to provide treatment, thereby establishing a physician-patient or hospital-patient relationship.[4] *See, e.g.*, *Brooks v. Maryland Gen. Hosp., Inc.*, 996 F.2d 708, 710 (4th Cir. 1993) ("[u]nder traditional state tort law, hospitals are under no legal duty to provide [emergency care to all]"); *Birmingham Baptist Hospital v. Crews*, 229 Ala. 398, 157 So. 224 (1934) (private hospital "owes the public no duty to accept any patient not desired by it"). By refusing to examine an individual in an emergency room or by shunting an individual off to another institution, the hospital avoided creating any hospital-patient relationship under state common law. Hence, it incurred no liability

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[3] The common law rule is based on a well-established principle of tort law that no one has a duty to protect any other person, unless a relationship exists between those individuals establishing a duty to act. *See* W. Page Keeton et al., Prosser and Keaton on The Law of Torts § 53, § 56 (5th ed. 1984).

[4] The agreement can either be a contract for which consideration is given or it can be a voluntary undertaking to provide care without charge. *See, e.g., Napier v. Greenzweig*, 256 F.196 (2d Cir. 1919). In either case, however, an affirmative agreement to treat is required before common-law duties attach to either the physician or the hospital.

under that law if the individual suffered injury because of the delay in treatment.

This gap in the common law is a narrow one. Once a physician-patient or hospital-patient relationship is established, *i.e.*, once the physician or hospital agrees to examine or treat an individual, then the law imposes a variety of duties. These include the duty of reasonable care, the duty not to provide unwanted medical treatment, and the duty not to abandon a patient after a physician-patient or hospital-patient relationship has been established. *See Bryan v. Rectors and Visitors of University of Virginia*, 95 F.3d 349, 351-52 (4th Cir. 1996); Restatement 2d of Torts § 323 (1965); Keeton, *supra*, at § 18, § 32, § 56; 61 Am. Jr. 2d, *Physicians, Surgeons, and Other Healers*, § 234, § 238 (1981). These common law duties have long played a critical role in regulating physician and hospital conduct toward patients in all States.

By 1986, a number of States had moved to close the gap that permitted emergency rooms to refuse any examination or treatment to particular individuals. *See* Karen H. Rothenberg, *Who Cares?: The Evolution of the Legal Duty to Provide Emergency Care*, 26 Hous. L. Rev. 21, 53-57 (1989) (discussing state efforts to prohibit "patient dumping"). But Congress was aware that these reform efforts were far from complete. *See* 131 Cong. Rec. S.13892 (1985) (Sen. Kennedy) ("Some states have laws which ensure that no emergency patient is denied emergency care because of inability to pay. But 28 states have no such law."). EMTALA was designed to create a uniform rule, applicable to all hospitals that receive federal Medicare funding, that would close that gap once and for all on a national basis. *See Gatewood v. Washington Healthcare Corp.*, 933 F.2d 1037,

1041 (D.C. Cir. 1991) (EMTALA's purpose is "to create a new cause of action, generally unavailable under state tort law, for what amounts to failure to treat").

Given the narrow remedial objective of EMTALA, it is clear that Congress did not intend to create a parallel system of federal liability that would be superimposed on top of the state common law duties that have long applied to established physician-patient and hospital-patient relationships. EMTALA expressly states that its provisions "do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section." 42 U.S.C. § 1395dd(f). And the statute borrows from state liability law in defining the remedies available to individuals who may bring a civil action for personal harm suffered as a direct result of a hospital's violation of the Act. *Id.* § 1395dd(d)(2)(A). Congress was clearly legislating interstitially, against the backdrop of well-established state liability law, and without any design of duplicating that law or interfering with its future development.

Every court of appeals that has considered EMTALA has recognized that the Act was not intended to create "a general federal cause of action for medical malpractice in emergency rooms." *Summers v. Baptist Medical Center Arkadelphia*, 91 F.3d 1132, 1137 (8th Cir. 1996) (en banc).[5]

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[5] *Marshall v. East Carroll Parish Hospital Service District*, 134 F.3d 319, 322 (5th Cir. 1998) (EMTALA "was not intended to be used as a federal malpractice statute"); *Correa v. Hospital San Francisco*, 69 F.3d 1184, 1192 (1st Cir. 1995), *cert. denied*, 517 U.S. 1136 (1996) ("EMTALA does not create a cause of action for medical malpractice"); *Eberhardt v. City of Los Angeles*, 62 F.3d 1253, 1258 (9th Cir. 1995) ("[t]he statutory language of the

(continued...)

As Chief Judge Richard Arnold of the Eighth Circuit has explained:

> The courts have construed the statute in this rather conservative fashion, we suppose, out of sensitivity to policies of federalism. Congress can of course, within constitutional limits, federalize anything it wants to. Whether it chooses to do so is a matter of policy for it to decide, not us. But in construing statutes that are less than explicit, the courts will not assume a purpose to create a vast new realm of federal law, creating a federal remedy for injuries that state tort law already addresses. If Congress wishes to take such a far-reaching step, we expect it to say so clearly.

Id. (citing *United States v. Bass*, 404 U.S. 336, 349 (1971)).[6]

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[5] (...continued)
EMTALA clearly declines to impose on hospitals a national standard of care"); *Power v. Arlington Hospital Association*, 42 F.3d 851, 856 (4th Cir. 1994) ("EMTALA is not a substitute for state law malpractice actions, and was not intended to guarantee proper diagnosis or to provide a federal remedy for misdiagnosis or medical negligence") (citations omitted); *Repp v. Anadarko Municipal Hospital*, 43 F.3d 519, 522 (10th Cir. 1994) (EMTALA "'is neither a malpractice nor a negligence statute'") (citation omitted); *Holcomb v. Monahan*, 30 F.3d 116, 117 (11th Cir. 1994) (EMTALA "is not designed to redress a negligent diagnosis by the hospital; no federal malpractice claims are created"); *Gatewood*, *supra*, 933 F.2d at 1041 (EMTALA "is not intended to duplicate preexisting legal protections, but rather to create a new cause of action, generally unavailable under state tort law"); *Cleland*, supra, 917 F.2d at 272 (by its terms, EMTALA "precludes resort to a malpractice or other objective standard").

[6] The constructional principle invoked by Chief Judge Arnold is, of course, fully consistent with this Court's more general teachings. This Court has long observed that "[t]he maintenance in our federal system of a proper (continued...)

B. EMTALA's Limited Federal Duties

The strategy that Congress adopted for closing the gap in state law that permitted dumping of persons from emergency rooms is based on a carefully defined, three-tier system of federal legal duties. These duties are set forth in subparts (a), (b), and (c) of EMTALA. Petitioner and the Solicitor General would have this Court interpret the words of subpart (b) -- the provision most directly applicable in this case -- in isolation from the other two parts. But it is not possible to grasp the import of any one of the three tiers of obligation without considering how they work together. Cumulatively, these three subparts describe a single coherent set of duties that define how hospitals and physicians must respond to individuals who seek assistance in hospital emergency rooms. The Act does not purport to govern any other aspect of physician-patient or hospital-patient relationships.

Subpart (a) imposes a duty on every hospital that receives Medicare funds and has an emergency room to perform an "appropriate medical screening examination" on any individual who comes to the emergency room seeking an

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[6] (...continued)
distribution between state and national governments of police authority and of remedies private and public for public wrongs is of far-reaching importance. An intention to disturb the balance is not lightly to be imputed to Congress." *Apex Hosiery Co. v. Leader*, 310 U.S. 469, 513 (1940). A corollary doctrine is that federal statutes should not be construed so as to alter the common law unless Congress has carefully considered and fully intended such a result. *See, e.g., United States v. Texas*, 507 U.S. 529, 534 (1993) ("`[s]tatutes which invade the common law...are to be read with a presumption favoring the retention of long-established and familiar principles, except when a statutory purpose to the contrary is evident'") (quoting *Isbrandtsen Co. v. Johnson*, 343 U.S. 779, 783 (1952)).

examination or treatment for a medical condition.[7] Subpart (a) is by far the broadest of the duties prescribed by EMTALA. It applies to any individual who presents at a hospital emergency room -- regardless of what kind of medical problem the individual may have and regardless of whether the patient is a Medicare beneficiary. Thus, the hospital must perform an "appropriate medical screening" on a child with a bruised knee as well as an accident victim near death.

Although broad, the duty set forth in subpart (a) is also carefully circumscribed. First, it expressly applies only to "a hospital emergency department." It does not apply to physician offices, clinics, nursing homes, hospices, or departments of hospitals other than the emergency room. *See Baber v. Hospital Corp. of America*, 977 F.2d 872, 884 (4th Cir. 1992).

Second, the statute specifically qualifies the appropriate screening examination requirement by saying that it is to be one "within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department." Thus, EMTALA does not impose a uniform federal standard of screening on hospital emergency rooms.[8] EMTALA merely requires that

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[7] The test of subpart (a) may be found at Petn. A55.

[8] *See Eberhardt*, *supra*, 62 F.3d at 1258 ("The statutory language of the EMTALA clearly declines to impose on hospitals a national standard of care in screening patients."); *Repp*, *supra*, 43 F.3d at 522 ("The phrase that modifies 'appropriate medical screening' reveals that the requisite standard, far from being uniform, varies with the particular conditions of each emergency room"); *Baber*, *supra*, 977 F.2d at 879-880 ("EMTALA does not

(continued...)

every hospital emergency room have some set of policies and procedures for screening individuals who present themselves and that these policies and procedures be applied uniformly to all individuals.[9] This "equal screening" construction of subpart (a) preserves the primary purpose of EMTALA — to prevent hospitals from refusing to examine indigent or uninsured individuals who come to emergency rooms — without federalizing standards of medical practice that traditionally have remained within the domain of the states.

Subpart (b) of EMTALA specifies the further duties that attach to a hospital if the "appropriate medical screening examination" mandated by subpart (a) results in a "determination" by the hospital that an "emergency medical condition exists."[10] The statute makes clear that such a determination is the condition precedent to any further EMTALA obligations beyond the initial emergency room

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[8] (...continued)
impose on hospitals a national standard of care in screening patients.").

[9] *See Marshall*, *supra*, 134 F.3d at 322 ("an EMTALA 'appropriate medical screening examination' is not judged by its proficiency in accurately diagnosing the patient's illness, but rather by whether it was performed equitably in comparison to other patients with similar symptoms"); *Summers*, *supra*, 91 F.3d at 1138 ("An inappropriate screening examination is one that has a disparate impact on the plaintiff"); *Vickers* v. *Nash General Hospital, Inc.*, 78 F.3d 139, 143 (4th Cir. 1996) ("EMTALA's requirement that individuals seeking emergency care receive an 'appropriate screening examination' obligates hospitals to 'apply uniform screening procedures to all individuals coming to the emergency room") (citation omitted); *Correa*, *supra*, 69 F.3d at 1192 ("hospital fulfills its statutory duty to screen patients in its emergency room if it provides . . . screening uniformly to all those who present substantially similar compiaints").

[10] The text of subpart (b) may be found at Petn. A55-56.

screening.[11] Subpart (a) concludes by saying that the medical screening is to be undertaken "to determine whether or not an emergency medical condition...exists." No other purpose of the screening is identified. And subpart (b) begins by conditioning its further duties with the clause: "If any individual...comes to a hospital *and the hospital determines that the individual has an emergency medical condition* . . ." (emphasis added). It follows that if a hospital determines that the individual has an emergency medical condition, the hospital is subject to further EMTALA duties under subparts (b) and (c). Conversely, if a hospital determines that the individual does not have an emergency medical condition, then EMTALA requires no further action on the part of the hospital.

Given the importance of the finding of an "emergency medical condition," it is not surprising that Congress provided a special definition of this concept. 42 U.S.C. § 1395dd(e)(1). That definition is narrowly drawn.[12] To qualify as an emergency medical condition, a condition must be one that manifests itself by "acute symptoms," including "severe pain," that a reasonable physician would conclude

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[11] Although subpart (b), unlike subpart (a), is not expressly limited to determinations made in an emergency department, this subpart logically must also be limited to individuals who enter the hospital through the emergency room. This is because the determination of whether a medical emergency condition exists must be based on the appropriate medical screening examination, and the duty to provide such a screening attaches only to individuals who enter through an emergency room. The question whether subpart (b) applies to an individual who enters a hospital through some department other than the emergency room is not presented in this case, because it is undisputed that Johnson entered Humana through its emergency department.

[12] The text of subpart(e)(1) may be found at Petn. A62-63.

requires "immediate medical attention" to avoid "serious jeopardy" to an individual's health, "serious impairment" of bodily functioning, or "serious dysfunction" of any bodily organ or part.

If the hospital determines that the individual has an emergency medical condition and decides to transfer the individual, then subpart (b) specifies that the hospital must either provide for further examination or treatment to stabilize the medical condition, or must comply with the informed consent requirements of subpart (c). The first option requires the hospital, "within the staff and facilities available," to assure "within reasonable medical probability" that the individual's condition will not deteriorate during the transfer. Thus, the duty to stabilize during transfer, like the duty to provide an appropriate medical screening to all individuals who come to an emergency room, is defined in terms of the particular capabilities of the hospital. No uniform federal standard is imposed.

The Sixth Circuit in *Cleland, supra,* held that subpart (b), like subpart (a), imposes at most a duty of equal treatment on hospitals. *Cleland, supra,* 917 F.2d at 272. Under this construction, a plaintiff in order to maintain a stabilization claim must show that a hospital failed to follow its normal produces in treating a particular individual. Petitioner does not challenge the validity of this disparate treatment standard.

The second option given by subpart (b), which is spelled out in subpart (c), requires obtaining either the informed consent of the individual or a physician's certificate

that the benefits of the transfer outweigh the risks.[13] It also requires that the transfer and the facility to which the transfer occurs be "appropriate" given the individual's medical condition.[14] No issue regarding the meaning of subpart (c) is presented in this case.

C. Petitioner And The Solicitor General Interpret EMTALA To Create A Broad Form Of Federal Malpractice Liability

Petitioner and the Solicitor General effectively ignore the carefully integrated set of federal duties prescribed by subparts (a), (b), and (c) of EMTALA. Instead, they take the language of subpart (b) out of context and focus on the duty to "stabilize" individuals before they are transferred. They note that subpart (b), unlike subpart (a), is not by its terms expressly limited to emergency departments of hospitals. And they note that the term "transfer" is defined to include "discharge." 42 U.S.C. § 1395dd(e)(4). From this, they conclude that EMTALA imposes a wide-ranging duty on covered hospitals to "stabilize" every patient who enters the hospital with an emergency medical condition before such patient is discharged. Pet. Br. at 20-21; Solic. Gen. Br. at 7. Petitioner evidently believes that EMTALA holds hospitals strictly liable for failing to stabilize patients before they are discharged. Pet. Br. at 24-25. The Solicitor General recognizes that strict liability is inappropriate, Solic. Gen. at 17, but nevertheless would have the Court adopt a broad construction of EMTALA as imposing a federal duty of objective "reasonableness" applicable to any discharge

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[13] The text of subpart(c)(1) may be found at Petn. A56.

[14] The text of subpart (c)(2) may be found at Petn. A58.

decision. *Id.* at 16-18.

These constructions of EMTALA are legally erroneous for the reasons set forth in Part II of this brief. More generally, the constructions urged by petitioner and the Solicitor General would make EMTALA the source of a sweeping federal cause of action for medical malpractice which would substantially duplicate state malpractice law. Any patient entering a hospital with an emergency medical condition who is admitted for treatment by the hospital would have a potential cause of action for damages under EMTALA on the ground that the patient's condition had not been adequately "stabilized."

The potential universe of individuals who could advance such claims would extend to every emergency patient who is admitted to the hospital. For example, a patient who entered a hospital with symptoms of a heart attack, was admitted to the hospital for treatment, and later suffered a second heart attack could bring an EMTALA action on the ground that he or she had not been properly "stabilized" after the first heart attack. There is no indication that Congress sought to establish such a broad cause of action overlapping existing state medical malpractice law. To the contrary, the creation of such a duplicate system of federal civil liability would give rise to a number of significant practical problems of great concern to *amici*.

First, the creation of a wide-ranging federal action for hospital malpractice could create pressure for a single uniform federal standard of reasonable care, usurping the traditional role of state common law in this area. This is not inevitable, since EMTALA limits the appropriate medical screening obligation to that "within the capability of the hospital's

emergency department," 42 U.S.C. § 1395dd(a), and limits the stabilization requirement to that "within the staff and facilities available at the hospital." *Id.* § 1395dd(b)(1)(A). This language should be read as excluding the development of uniform federal standards of medical care. But EMTALA's duties are federal duties, and courts applying these duties are likely to look to precedents from other federal courts or to regulations issued by the Secretary of Health and Human Services in resolving particular cases.[15] Over time, a certain pressure could arise tending toward the establishment of federal minimum standards, which would then evolve into a general uniform federal standard crowding out state standards. This would undermine all the advantages of allowing states to develop different standards that are responsive to different local values and conditions. *Cf. Hamelin v. Michigan*, 501 U.S. 957, 990 (1991) ("Diversity not only in policy, but in the means of implementing policy, is the very *raison d'etre* of our federal system.")

Second, the creation of a broad federal cause of action for hospital malpractice would give rise to widespread forum-shopping. This is because claimants would be able to assert, in addition to their federal EMTALA claim and without regard to the amount in controversy, state-law medical malpractice claims under supplemental jurisdiction. *See e.g.*, *Jones v. Garcia*, 936 F.Supp. 929 (M.D. Fla. 1996) (in action arising under EMTALA, district court exercised its supplemental jurisdiction over medical malpractice claims controlled by Florida law). A broad EMTALA cause of

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[15] Some courts have suggested that EMTALA creates a minimum federal standard of appropriate screening, *see Correa*, *supra*, 69 F.3d at 1192, and have held that EMTALA imposes stabilization duties that exceed those required by state law, *see Matter of Baby K*, 16 F.3d 590, 596-97 (4th Cir. 1994), *cert. denied*, 513 U.S. 825 (1994).

action would therefore create expanded opportunities for claimants to choose which forum to hear their state malpractice cases -- federal court or state court. This expanded potential for forum shopping is unfair to defendants, and the increased skirmishing over preliminary jurisdictional issues would increase the costs of litigation.

Third, the creation of such a duplicate system of civil liability in federal courts would complicate efforts of state legislatures to make reforms in the common-law tort system. Many states, for example, have instituted certain types of alternative dispute resolution as a way of seeking to resolve claims involving physicians and hospitals. *See* John F. Bales, *Medical Malpractice Developments*, 700 PLI/Comm 563, 570-79 (1994) (discussing prevalence of state-mandated or encouraged use of alternative dispute resolution in medical malpractice litigation). Claimants might be able to evade such requirements by the expedient of filing a federal EMTALA claim, which is necessarily a civil action tried in court, and asserting their state claims under supplemental jurisdiction. Because *amici* support many of the efforts by state legislatures to reform the tort system, they strongly oppose any expansionist interpretation of EMTALA that could permit an end run around these experiments. *Cf. New State Ice Co. v. Liebman*, 285 U.S. 262, 311 (1932) (Brandeis J., dissenting) ("It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.").

These practical concerns, of course, would not be sufficient to defeat EMTALA liability if Congress had created a general federal cause of action for hospital and physician

malpractice. In fact, however, it is quite clear that the structure, purpose, and language of the statute require the opposite conclusion.

II. THE SIXTH CIRCUIT CORRECTLY CONCLUDED THAT EMTALA DOES NOT PERMIT THE IMPOSITION OF LIABILITY ON THE RESPONDENT HOSPITAL IN THIS CASE

The judgment below is correct and should be affirmed. The lower courts dismissed petitioner's EMTALA action because there is no evidence that the physicians who signed Wanda Johnson's discharge papers were motivated by financial or other impermissible considerations. The Sixth Circuit's focus on the treating physicians' state of mind, first articulated in *Cleland, supra,* and then applied in the decision below, confines the scope of EMTALA liability to those situations where Congress intended that there would be liability. Under this approach, hospitals and physicians would not be subject to civil liability under EMTALA unless it could be shown that they had a non-medical reason, other than negligence, for failing to provide the same screening examinations and stabilization efforts to all individuals who come to a hospital emergency room seeking assistance. The court adopted this standard to ensure that EMTALA would not become a general substitute for state tort law. In contrast, both the strict liability construction urged by petitioner, and the objective reasonableness interpretation favored by the Solicitor General, would open the floodgates to broad federal liability that would substantially overlap traditional state tort remedies.

Amici urge this Court to affirm the Sixth Circuit's

improper motive test or some other limiting interpretation of the statute. The court of appeals' interpretation is clearly consistent with Congress' desire that EMTALA not be construed to create a federal cause of action for malpractice or a national standard of emergency medical care. Given the disparity between this clear legislative intent and the facially broad language of the statute, it is imperative the Court adopt some narrowing construction of the text of the statute, as it has done in similar circumstances. *See, e.g., Public Citizen* v. *United States Department of Justice*, 491 U.S. 440 (1989); *Rector* v. *Holy Trinity Church* v. *United States*, 143 U.S. 457 (1892). Indeed, virtually all of the courts of appeals that have interpreted EMTALA have applied some narrowing construction.

In any case, the Court need not embrace the improper motive standard in order to reach the right result in this case. There are two additional reasons, both fully supported by the language and structure of EMTALA -- and both well established in the decisions of the courts of appeals -- why judgment was properly entered for the respondent hospital. Specifically, *amici* request this Court to hold that (a) EMTALA does not apply once an individual has been admitted to the hospital and (b) EMTALA is not violated where the responsible physicians did not believe that the individual had an emergency medical condition at the time of transfer. Affirmance on either of these grounds would be fully supported by the law and the record in this case and would not expand the relief which has been granted. *See Schenck v. Pro-Choice Network of Western New York*, 117 S.Ct. 855, 870 n.12 (1997) (and cases cited). Moreover, like the Sixth Circuit's implied improper motive test, these grounds would confine the scope of EMTALA to the narrow gap-filling duties that Congress intended.

A. EMTALA Imposes No Duties On Hospitals With Respect To Individuals Who Are Admitted To The Hospital For Treatment

Petitioner alleges that respondent violated EMTALA by failing "to stabilize" Johnson prior to her discharge on July 24, 1992. This claim necessarily fails because the duty to stabilize applies only through the processing of the emergency condition that exists at the time the individual initially presents at the hospital. It does not apply to emergencies that arise after an individual has been admitted to the hospital for treatment. Once an individual is admitted, the hospital's duty to the individual is governed by state malpractice law, not by EMTALA.

The statutory language fully supports this conclusion. The subpart (b) duties are triggered when "any individual . . . *comes to a hospital* and the hospital determines that the individual has an emergency medical condition . . ." This language indicates that Congress was concerned with the initial presentation of the individual that occurs before a hospital-patient relationship is established.[16] It is also significant that EMTALA never uses the word "patient" to describe the persons protected by the federal duties created in

[16] The most likely reason that Congress referred to "hospitals" rather than "emergency departments" in subparts (b) and (c) is because subpart (a) requires that the determination whether an emergency medical condition exists be made "within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department." 42 U.S.C. § 1395dd(a). Thus, for example, an individual who comes to an emergency room may be taken to the radiology department for x-rays. Congress did not want to create a loophole that would permit the hospital to transfer individuals from the radiology department to another facility without assuring that they had first been stabilized.

subparts (a), (b), and (c). Instead, it refers throughout to these persons as "individuals." Other sections of the Medicare statutes refer to covered persons as "patients" in a context where a physician-patient or hospital-patient relationship exists. *See e.g.*, 42 U.S.C. § 1395xx(a); 42 U.S.C. § 1395ww(a). This too suggests that Congress was not legislating for persons who have been admitted to a hospital for treatment and who therefore have entered into a hospital-patient relationship.

Two important structural features of EMTALA support the conclusion that EMTALA applies only to individuals who have not been admitted by the hospital. First, as demonstrated in Part IB, *supra*, subpart (b)'s requirement that the hospital determine that an emergency medical condition exists is closely linked to subpart (a)'s requirement of an appropriate medical screening examination. And the requirement of an appropriate medical screening examination is expressly limited to individuals who seek assistance in a hospital "emergency department." It follows that the emergency medical condition to which subpart (b) refers must be a condition that was discovered through the initial screening conducted in the emergency room.

This means, at the very least, that the emergency medical condition that triggers duties with respect to transfer must be *the same* emergency condition that brought the individual to the hospital, not a condition that developed only later. That alone is enough to defeat any EMTALA liability in this case. Further, the linkage between subpart (a) and subpart (b) suggests that the latter subpart applies only to transfers that occur from the emergency room, or that occur immediately after the medical screening examination has been completed -- not transfers that occur after the individual has

been admitted for treatment.

Second, EMTALA imposes no federal duties on hospitals with respect to patients who are admitted for treatment. The additional duties imposed by EMTALA if the hospital determines that an individual has an emergency medical condition attach only if the hospital decides *to transfer* the patient to another facility. The failure to address the very common situation of an individual who presents at an emergency room and who is admitted to the hospital strongly suggests that Congress did not consider this a problem to be addressed by federal law.[17]

The fact that the duty to stabilize is limited to transfers does not appear immediately from the face of subpart (b), but emerges from the definitions. Subpart (b) provides that if a hospital determines that the individual has an emergency medical condition, it

> must provide either --
>
> **(A)** within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required *to stabilize* the medical condition, or

[17] EMTALA defines "transfer" to include "discharge." 42 U.S.C. § 1395dd(e)(4). But this does not expand the coverage of the statute beyond transfers that occur immediately after the determination in the emergency room that an individual has an "emergency medical condition." Congress was obviously concerned not only with how emergency rooms transport critically ill or injured patients to other facilities, but also with the possibility that such an individual would simply be discharged from the emergency room.

> **(B)** for transfer of the individual to another medical facility in accordance with subsection (c) of this section (emphasis added).

Standing alone, the first of these alternatives might be read as imposing some free-floating requirement "to stabilize" all individuals having emergency medical conditions in hospitals. But the Act contains specific definitions of the terms "stabilize" and "to stabilize," which are substantively identical.[18] Both definitions focus on the need to prevent deterioration of the individual's condition during a transfer. The hospital must assure, "within reasonable medical probability, that no material deterioration of the [emergency medical] condition is likely to result from or occur *during the transfer* of the individual from a facility" (emphasis added).

The reason that EMTALA does not address the case of the individual with an emergency medical condition who is admitted for treatment is that the decision to admit the individual creates a hospital-patient relationship. Once this relationship is formed, the quality of the care and treatment that the patient receives are fully governed by preexisting sources of state law, including malpractice law. Consequently, it was not necessary to legislate any new federal duties to cover this situation.[19]

[18] The definitions of the terms "stabilize" and "to stabilize" may be found at Petn. A63-64.

[19] EMTALA itself cannot be construed as imposing a hospital-patient relationship or a physician-patient relationship and hence triggering the full panoply of common-law duties. The common law requires a voluntary undertaking to treat by a physician or a hospital to create such a relationship. *See* p.1 & n.4 *supra*. Compliance with a narrow federal mandate does not

(continued...)

The understanding that EMTALA's stabilization requirement does not apply to an individual who has been admitted to the hospital for treatment as a patient has been endorsed by the only federal court of appeals squarely to address this question. *Bryan*, *supra*, 95 F.3d at 352.[20] There, an individual came to the hospital in an emergency condition and was admitted for treatment as a patient. After 12 days, the hospital entered a "do not resuscitate" order, allegedly against the wishes of the family. The patient died 8 days later. The family then sued under EMTALA, claiming that the failure to resuscitate constituted a breach of subpart (b)'s the duty "to stabilize" a patient with an emergency medical condition. The court rejected the claim, holding that EMTALA's stabilization requirement

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[19] (...continued)
constitute a voluntary agreement to treat. Moreover, whether or not a hospital-patient relationship or a physician-patient relationship could be imposed by a properly drawn state or federal statute, EMTALA is not such a law. The duty to treat imposed by EMTALA is narrowly confined to determining whether an individual has an emergency medical condition and if so, to assuring that the individual is stabilized or has given consent before being transferred. Nothing in the language of EMTALA suggests that hospitals or physicians must go further, as the respondent hospital did in this case, and assume a general duty of care of individuals as patients.

[20] *See also Collins v. DePaul Hospital*, 963 F.2d 303 (10th Cir. 1992) (holding that no claim for inappropriate screening under subpart (a) of EMTALA could be brought where as a result of the examination the individual was admitted to the hospital for treatment as a patient). This interpretation has been rejected by one state court. *See Smith* v. *Richmond Memorial Hospital*, 243 Va. 445, 416 S.E.2d 689 (1992) (holding that EMTALA applies to any emergency condition that occurs in a hospital, even after the patient has been admitted). *Cf. Thorton v. Southwest Detroit Hospital*, 895 F.2d 1131 (6th Cir. 1990) (holding that once a patient is found to suffer from an emergency medical condition in the emergency room, she cannot be discharged until the condition is stabilized, even if the patient has been admitted to another department of the hospital).

> . . . was intended to regulate the hospital's care of the patient only in the immediate aftermath of the act of admitting her for emergency treatment and while it considered whether it would undertake longer-term full treatment or instead transfer the patient to a hospital that could and would undertake that treatment. It cannot plausibly be interpreted to regulate medical and ethical decisions outside that narrow context.

Id. at 352.

The holding of *Bryan* is supported by the language, the structure, and the purposes of EMTALA That holding is fully applicable to Johnson's circumstances. Indeed, Johnson was admitted and treated for two months -- a far longer period than the patient in *Bryan*. Under *Bryan*, therefore, any claim that Johnson had against the hospital based on an allegedly negligent or premature discharge should be based on state malpractice law or the tort of abandonment, *id.*, not EMTALA. For this reason, summary judgment was properly entered for respondent.

B. EMTALA Imposes No Duty To Stabilize Unless The Responsible Physicians Believe The Individual Had An Emergency Medical Condition At The Time Of Transfer

Respondent was also under no EMTALA duty "to stabilize" Johnson at the time of her discharge because its treating physicians did not believe that she had "an emergency medical condition" at that time. It is undisputed that Johnson had an emergency medical condition when she was brought to Humana after her accident. But her treating physicians

testified that when she was discharged after two months of treatment, they did not perceive her as having an emergency medical condition. That testimony was uncontradicted, and requires that summary judgment be entered for respondent.

As noted in Part IB, *supra*, the hospital's determination that an individual has an emergency medical condition is the condition precedent to concluding that the hospital is under any further EMTALA duty with respect to the transfer of an individual. If the hospital determines there is no emergency medical condition, then EMTALA imposes no duty beyond the appropriate medical screening required by subpart (a). Only if the hospital concludes the individual has an emergency medical condition does EMTALA require that the individual be stabilized before transfer or that the transfer take place within the requirements of subpart (c).

Moreover, the statute provides that these additional duties with respect to transfer apply only when an individual comes to a hospital "and the hospital *determines* that the individual has an emergency medical condition." 42 U.S.C. § 1395dd(b) (emphasis added). In order "to determine" that an emergency medical condition exists, the hospital -- or rather physicians practicing at the hospital -- must have actual knowledge that such a condition exists.[21]

The plain language of subpart (b) admits of no other interpretation on this point. Not surprisingly, therefore,

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[21] To "determine" in this context means to "discover," *see* Webster's Third New International Dictionary 616 (1993), or to "ascertain," *see* The Random House Dictionary of the English Language 542 (2d ed. 1987); Ballantine's Law Dictionary 344 (3d ed. 1969). Either to discover or to ascertain that a particular conditions exists requires actual knowledge that the condition exists.

seven circuits have held that the hospital must have actual knowledge of the patient's emergency condition before the duty to stabilize attaches, and no circuit has held to the contrary.[22] As the Fourth Circuit explained in *Vickers, supra*, 78 F.3d at 145 (citations omitted) (emphasis in original):

> [A] stabilization claim exists when "the patient had an emergency condition" and "the hospital *actually knew* of *that* condition." The Act does not hold hospitals accountable for failing to stabilize conditions of which they are not aware, or even conditions of which they should have been aware. EMTALA would otherwise become coextensive with malpractice claims for negligent treatment.[23]

It would be very difficult to argue that Wanda Johnson had an "emergency medical condition" prior to her discharge on July 24, 1992. She did not manifest any "acute symptoms...(including severe pain)." 42 U.S.C. § 1395dd(e)(1). Her medically significant symptoms were a low grade fever, an elevated white cell count, and cloudy

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[22] *See, e.g., Marshall, supra,* 134 F.3d at 325; Summers, *supra,* 91 F.3d at 1140; *Eberhardt*, 62 F.3d at 1258-59; *Holcomb*, *supra* at 117; *Urban by and Through Urban* v. *King*, 43 F.3d 523, 525-27 (10th Cir., 1994); *Baber*, *supra,* 977 F.2d at 883; *Cleland*, *supra,* 917 F.2d at 269.

[23] Imposing such a subjective state of mind as a condition precedent for triggering the duties of subpart (b) makes sense given the structure of EMTALA. Because the identification of an emergency medical condition is based on the "appropriate medical screening examination" mandated by subpart (a), information generated by this screening will vary with "the capability of the hospital's emergency department" and with the different symptoms and history that each individual presents. Thus, it would be impossible to impose a uniform objective conception of "emergency medical condition" that would apply to all hospitals and all patients.

urine samples. J.A. 126-127. She was being given antibiotics for a suspected urinary tract infection. J.A. 126. There was no indication that any other "immediate medical attention" was warranted to prevent serious jeopardy to her health, or serious impairment to her bodily functions, or serious dysfunction to any bodily organ or part.

But the question is not whether, objectively speaking, Johnson had an emergency medical condition on July 24, 1992. The question is whether her treating physicians at Humana determined that she had an emergency medical condition. The deposition testimony and affidavits filed in the district court reveal conclusively that Johnson's physicians did not perceive that Johnson had an emergency medical condition. *See* J.A. 103, 117, 131, 133, 135. This testimony was uncontradicted.

Accordingly, summary judgment should also have been entered for respondent on the ground that the treating physicians had no actual knowledge of an emergency condition at the time of the transfer. If the treating physicians acted negligently in discharging Ms. Johnson when they did, she would have an action under state law. But on the uncontested facts presented, petitioner has no claim under EMTALA.

CONCLUSION

For the foregoing reasons, the judgment of the Sixth Circuit should be affirmed.

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